CABINET FOR HEALTH SERVICES

Department for Medicaid Services

Division of Financial Management

(Amendment)

907 KAR 1:640. Income standards for Medicaid.

RELATES TO: KRS 205.520, 38 U.S.C. 5503, 42 U.S.C. 1396jj(b), 1382a, 1397aa, 9902(2)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 435, 42 U.S.C. 1396a, b, d, 1397aa and Pub. L. 106-170

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services has responsibility to administer the Medicaid Program in accordance with 42 U.S.C. 1396 through 1396v. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provisions of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the income standards by which eligibility is determined.

Section 1. Definitions.

(1) "ABD" means an individual who is aged, blind, or disabled.

(2) "AFDC" means the Aid to Families with Dependent Children Program as it existed on July 16, 1996.

(3) "Child" means a person who:

(a)1.a. Is under the age of eighteen (18); or

b. Is under the age of nineteen (19) if the person is:

(i) In high school or the same level of vocational or training school; and

(ii) Expected to graduate before or during the month of his 19th birthday;

2. Is not self-supporting;

3. Is not a member of the Armed Forces of the United States; and

4. If previously emancipated by marriage, has returned to the home of his parents or to the home of another relative; or

(b) Has not attained nineteen (19) years of age as specified in 42 U.S.C. 1396a(l)(1).

(4) "Family alternatives diversion payment" means a lump sum payment made to a K-TAP applicant to meet short-term emergency needs.

(5) “Federal register” means the daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as executive orders and other presidential documents.

(6) "Incapacity" means a condition of mind or body making a parent physically or mentally unable to provide the necessities of life for a child.

(7)[~~(6)~~] "Income" means money received from statutory benefits (including Social Security, Veteran's Administration pension, black lung benefits, or railroad retirement benefits), pension plans, rental property, investments, or wages for labor or services.

(8)[~~(7)~~] "Lump sum income" means money received at one (1) time which is normally considered as income, including accumulated back payments from Social Security, unemployment insurance, or workman's compensation;[~~,~~] back pay from employment;[~~,~~] money received from an insurance settlement, gift, inheritance, or lottery winning;[~~,~~

~~noncontinuing~~] proceeds from a bankruptcy proceeding; or[~~,~~] money withdrawn from an IRA, KEOGH plan, deferred compensation, tax deferred retirement plan, or other tax deferred asset.

(9) “Medicaid works individual” means an individual who:

(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be receiving supplement security income;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;

2. Tax returns;

3. 1099 forms; or

4. Proof of quarterly estimated tax;

(d) Meets income standards established in this administrative regulation; and

(e) Meets resource standards established in 907 KAR 1:645, Resource standards for Medicaid.

(10)[~~(8)~~] "Minor parent" means a parent under the age of twenty-one (21).

(11)[~~(9)~~]"Official poverty income guidelines" means the poverty income guidelines which are:

(a) Updated annually in the Federal Register by the United States Department of Health and Human Services, under authority of 42 U.S.C. 9902(2); and

(b) The latest poverty guidelines available as of March 1 of the particular state fiscal year.

(12)[~~(10)~~] "SSI" means supplemental security income program.

Section 2. Income Limitations.

(1) For the medically needy as described in 907 KAR 1:011, Technical eligibility requirements, income shall be determined by comparing adjusted income as required by Section 3 of this administrative regulation, of the applicant, applicant and spouse, or applicant, spouse, and minor dependent children with the following scale of income protected for basic maintenance:

Size of Family	Annual	Monthly
1	$2,600	$217
2	3,200	267
3	3,700	308
4	4,600	383
5	5,400	450
6	6,100	508
7	6,800	567

For each additional family member, $720 annually or sixty (60) dollars monthly shall be added to the scale.

(2) The following special factors shall be applicable for a pregnant woman or child eligible pursuant to 42 U.S.C. 1396a(e):

(a) A pregnant woman or a child under age one (1) shall have family income not exceeding 185 percent of the official poverty income guidelines;

(b) A child age one (1) or over but under age six (6) shall have family income not

exceeding 133 percent of the official poverty income guidelines;

(c) A child born after September 30, 1983, who has attained six (6) years of age but has not attained nineteen (19) years of age shall have family income not exceeding 100 percent of the official poverty income guidelines;

(d) A pregnant woman or child who would be eligible under provisions of 42 U.S.C. 1396a(l) or 1397jj(b) except for income in excess of the allowable standard shall not become eligible by spending down to the official poverty guidelines as described in Section 9 of this administrative regulation;

(e) A change of income that occurs after the determination of eligibility of a pregnant woman shall not affect the pregnant woman's eligibility through the remainder of the pregnancy including the postpartum period which ends at the end of the month containing the 60th day of a period beginning on the last day of her pregnancy;

(f) A targeted low-income child as specified in 907 KAR 1:011, Technical eligibility requirements, Section 2(3)(h), shall have family income not exceeding 150 percent of the official poverty income guidelines.

(3) The following special income limits and provisions shall be applicable for a determination of eligibility of a qualified Medicare beneficiary, specified low-income Medicare beneficiary, qualified disabled working individual, or Medicare qualified individual.

(a) A qualified Medicare beneficiary shall have income not exceeding 100 percent of the official poverty income guidelines.

(b) A specified low-income Medicare beneficiary shall have income greater than 100 percent of the official poverty income guidelines but not to exceed 120 percent of the

official poverty income guidelines.

(c) A Medicare qualified individual shall have income greater than 120 percent of the official poverty income guidelines but less than or equal to 135 percent of the official poverty income guidelines.

(d) A qualified disabled working individual shall have income not exceeding 200 percent of the official poverty income guidelines.

(4) Income shall be limited to the allowable amounts for the SSI Program for:

(a) A child who lost eligibility for supplemental security income benefits due to the change in the definition of childhood disability as established in 42 U.S.C. 1396a(a)(10); or

(b) A person with hemophilia who received a class action settlement as established in 42 C.F.R. 435.122.

(5) Income shall be limited to the allowable amounts for the State Supplementation Program for a pass through recipient as established in 42 C.F.R. 435.135.

added to the scale.

(6) The following special income factors shall apply for a Medicaid works individual:

(a) Income for a Medicaid works individual's spouse shall not exceed $45,000 per year;

(b) A Medicaid works individual's unearned income shall be less than the SSI standard plus twenty (20) dollars; and

(c) The combination of earned and unearned income for a Medicaid works individual must be less than 250% of the federal poverty level as listed and updated annually in the Federal Register by the United States Department of Health and Human Services

under the authority of 42 U.S.C. 9902(2).

Section 3. Income Disregards. In comparing income with the scale established in Section 2 of this administrative regulation, gross income shall be adjusted as follows:

(1) In an AFDC or family related Medicaid case, the standard work expense of an adult member or out-of-school child shall be deducted from gross earnings. For a person with either full-time or part-time employment, the standard work expense deduction shall be ninety (90) dollars per month. Earnings of an individual attending school who is a child or parent under age nineteen (19) or a child under age eighteen (18) who is a high school graduate shall be disregarded.

(2) In an AFDC or family related Medicaid case, a dependent child care work expense shall be allowed for a child who is living in the home of the caretaker and is related to the caretaker in accordance with 907 KAR 1:011, Technical eligibility requirements, Section 5(9)(b), for full-time and part-time employment.

(a) The dependent child care work expense shall be deducted after all other disregards have been applied.

(b) The dependent child care work expense allowed shall not exceed, per month:

1. $200 for full-time or part-time employment per child under age two (2); and

2. $175 for full-time employment or $150 for part-time employment per:

a. Child age two (2) or above; or

b. Incapacitated adult.

(3) For an AFDC-related Medicaid case, a thirty (30) dollar and one-third (1/3) deduction of earned income shall be allowed in accordance with 921 KAR 2:016.

(4) Income disregards for:

(a) [~~In~~] An ABD Medicaid case shall be the applicable federal SSI disregards pursuant to 42 U.S.C. 1382a(b).

(b) A Medicaid works individual shall be the applicable federal SSI disregards pursuant to 42 U.S.C. 1382a(b)[~~, income disregards shall be those applicable in the federal SSI program established in 42 U.S.C. 1382a(b)~~].

Section 4. Income of the Stepparent or Parent of a Minor Parent referred to as a "Grandparent". An incapacitated stepparent's income, or a grandparent's income, shall be considered in the same manner as for a parent if the stepparent or grandparent is included in the family case. If the stepparent or grandparent living in the home is not being included in the family case, the stepparent's gross income shall be considered available to the spouse or the grandparent's gross income shall be considered available to the minor parent in accordance with the requirements established in this section. The following disregards and exclusions from income shall be applied:

(1) The first ninety (90) dollars of the gross earned income of the stepparent or grandparent who is employed full time or part time;

(2) An amount equal to the appropriate income limitations scale established in Section 2 of this administrative regulation for the appropriate family size, for the support of the stepparent or grandparent and other individuals (not including the spouse or minor parent) living in the home whose needs are not taken into consideration in the Medicaid eligibility determination but are claimed by the stepparent or grandparent as dependents for purposes of determining federal personal income tax liability;

(3) Any amount actually paid by the stepparent or grandparent to an individual not living in the home who is claimed by him as a dependent for purposes of determining

his personal income tax liability;

(4) A payment by the stepparent or grandparent for alimony or child support with respect to an individual not living in the household;

(5) Income of a stepparent or grandparent receiving SSI; and

(6) Verified medical expenses for the stepparent or grandparent and his dependents in the home.

Section 5. Lump Sum Income. For a Medicaid case, lump sum income shall be considered as income in the month received.

Section 6. Income Exclusions.

(1) Income of a person who is blind or disabled necessary to fulfill an approved plan for achieving self-support (PASS), impairment related work expense (IRWE) deduction, or the blind work expense (BWE) deduction shall be excluded from consideration.

(2) A payment or benefit from a federal statute, other than SSI benefits, shall be excluded from consideration as income if precluded from consideration in SSI determinations of eligibility by the specific terms of the statute.

(3) A cash payment intended specifically to enable an applicant or recipient to pay for medical or social services shall not be considered as available income in the month of receipt.

(4) A Federal Republic of Germany reparation payment shall not be considered available in the eligibility or posteligibility treatment of income of an individual in a nursing facility or hospital or who is receiving home and community based services under a waiver.

(5) A Social Security cost of living adjustment on January 1 of each year shall not be

considered as available income for a qualified Medicare beneficiary, specified low-income Medicare beneficiary, qualified disabled working individual, or Medicare qualified individual until after the month following the month in which the official poverty guideline promulgated by the Department of Health and Human Services U.S. Government is published.

(6) Any amount received from a victims compensation fund established by a state to aid victims of crime shall be excluded as income.

(7) A veteran or the spouse of a veteran residing in a nursing facility who is receiving a Veterans Administration (VA) benefit shall have ninety (90) dollars:

(a) Excluded as income in the Medicaid eligibility determination; and

(b) Excluded as income in the posteligibility determination process.

(8) Veterans Administration payments for unmet medical expenses (UME) and aid and attendance (A&A) shall be excluded in a Medicaid eligibility determination for a veteran or the spouse of a veteran residing in a nursing facility.

(a) Veterans Administration payments for unmet medical expenses (UME) and aid and attendance (A&A) shall be excluded in the posteligibility determination for a veteran or the spouse of a veteran residing in a nonstate-operated nursing facility.

(b) Veterans Administration payments for unmet medical expenses (UME) and aid and attendance (A&A) shall not be excluded in the posteligibility determination process for a veteran or the spouse of a veteran residing in a state-operated nursing facility.

(9) An Austrian Social Insurance payment based, in whole or in part, on a wage credit granted under Sections 500-506 of the Austrian General Social Insurance Act shall be excluded from income consideration.

(10) An individual retirement account, KEOGH plan, or other tax deferred asset shall be excluded as income until withdrawn.

(11) Disaster relief assistance shall be excluded as income.

(12) Income which is exempted from consideration for purposes of computing eligibility for the comparable money payment program (AFDC and SSI) shall be excluded[~~exempted from consideration by the department~~].

(13) In accordance with 42 C.F.R. 435.122 and Section 4735 of Pub.L. 105-33, a payment made from a fund established by a settlement in the case of Susan Walker v. Bayer Corporation or payment made for release of claims in this action shall be excluded as income.

(14) In accordance with 42 C.F.R. 435.122, any payment received by a person with hemophilia from a class action law suit entitled "Factor VIII or IX Concentrate Blood Products Litigation" shall be excluded as income.

(15) Family alternatives diversion payments shall be excluded as income.

(16) For an AFDC or family-related Medicaid case, a Medicaid recipient shall have the option to receive a one (1) time exclusion of two (2) months of earned income for new employment or increased wages acquired after approval and reported timely.

(17) For an AFDC-related or a family-related Medicaid case, interest and dividend income shall be excluded.

(18) All monies received by an individual from the Tobacco Settlement between the states and tobacco manufacturers shall be excluded.

(19) Income placed in a qualifying income trust established in accordance with 42 U.S.C. 1936p(d)(4) and 907 KAR 1:650, Trust and transferred resource requirements

for Medicaid, Section 3(5), shall be excluded.

Section 7. Consideration of State Supplementary Payments. For an individual receiving a state supplementary payment, that portion of the individual's income which is in excess of the basic maintenance standard (established in Section 2(1) of this administrative regulation) shall be applied to the special need which results in the supplementary payment.

Section 8. Pass-through Cases.

(1)(a) An increase in a Social Security payment shall be disregarded in determining eligibility for Medicaid benefits if:

1. The increase is a cost of living increase; and

2. The individual would otherwise be eligible for an SSI benefit or state supplementary payment.

(b) An individual who would otherwise be eligible for an SSI benefit or state supplementary payment shall remain eligible for the full scope of program benefits with no spend-down requirements, as established in Section 9 of this administrative regulation.

(2) For an individual who applied by July 1, 1988, the additional amount specified in 42 U.S.C. 1383c(b) shall be disregarded, meaning that amount of Social Security benefits to which a specified widow or widower was entitled as a result of the recomputation of benefits effective January 1, 1984, and except for which (and subsequent cost of living increases) an individual would be eligible for federal SSI benefits.

Section 9. Spend-down Provisions.

(1) A technically eligible individual or family shall not be required to utilize protected income for medical expenses before qualifying for Medicaid.

(2) An individual with income in excess of the basic maintenance scale established in Section 2(1) of this administrative regulation may qualify for Medicaid in any part of a three (3) month period in which medical expenses incurred have utilized all excess income anticipated to be in hand during that period.

(3) Medical expenses incurred in a period prior to the quarter for which spend-down eligibility is being determined may be used to offset excess income if the medical expenses remain unpaid at the beginning of the quarter and have not previously been used as spend-down expenses.

907 KAR 1:640

REVIEWED:

Date	Shawn M. Crouch, Commissioner Department for Medicaid Services

APPROVED:

Date	Mark D. Birdwhistell, Secretary Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on January 21, 2008 at 9:00 a.m. in the Cafeteria on the first floor of the Human Resources Building, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by January 14, 2008, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business January 31, 2008. Please send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: 502-564-7905, Fax: 502-564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:640
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes provisions related to Medicaid eligibility income standards.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish provisions related to Medicaid eligibility income standards.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing provisions related to Medicaid eligibility income standards.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing provisions related to Medicaid eligibility income standards.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment results from a congressional initiative to encourage states to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment. The initiative creates a new Medicaid eligibility group known as Medicaid works individuals. Currently, individuals receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) who choose to work, lose Medicaid health benefits because their income exceeds the allowable limit. This initiative will allow individuals with disabilities who choose to work and whose income is less than or equal to 250% of the federal poverty level the opportunity to purchase Medicaid coverage by paying a premium. Currently individuals who qualify via a spend down option receive benefits for three (3) months and then have to return to a local office and re-apply each time they desire a spend down eligibility card. If these individuals elect to be covered via the Medicaid works option they will simply pay a monthly premium and not have to continue returning to a local office to qualify via spend down. Additionally, this option allows individuals to increase their expendable income by working and maintaining Medicaid eligibility rather than having to choose between working and preserving Medicaid benefits. The special income factors established in this administrative regulation for Medicaid works individuals exceed those established for other recipients and result from a review of other states' standards as well as feedback from the advocate community.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to extend Medicaid coverage to individuals with disabilities who work. Currently individuals who qualify via a spend down option receive benefits for three (3) months and then have to return to a local office and re-apply each time they desire a spend down eligibility card. If these individuals elect to be covered via the Medicaid works option they will simply pay a monthly premium and not have to continue returning to a local office to qualify via spend down. Additionally, this option allows individuals to increase their expendable income by working and maintaining Medicaid eligibility rather than having to choose between working and preserving Medicaid benefits. The special income factors established in this administrative regulation for Medicaid works individuals exceed those established for other recipients and result from a review of other states' standards as well as feedback from the advocate community.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by ensuring that provisions relating to eligibility requirements are within the limits established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by ensuring that provisions relating to eligibility requirements are within the limits established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect individuals with disabilities between the ages of sixteen (16) and sixty-five (65) who choose to work and whose income is less than or equal to 250% of the federal poverty level.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Individuals choosing Medicaid coverage via this option must pay a monthly premium in order to receive benefits under this program. In addition, recipients must pay nominal co-payments for specified services.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Members eligible via the Medicaid works option will be subject to pharmacy and medical co-payments that are capped at $225 each per year per recipient. Therefore, the maximum amount of co-payments per recipient will be $450 per year. In addition, recipients will be responsible for a monthly premium based on income levels. Premiums range from thirty-five (35) dollars to fifty-five (55) dollars.

(c) As a result of compliance, what benefits will accrue to the entities identified in

question (3). Individuals eligible via the Medicaid works option will receive pharmacy and medical benefits through the Medicaid program. Currently individuals who qualify via a spend down option receive benefits for three (3) months and then have to return to a local office and re-apply each time they desire a spend down eligibility card. If these individuals elect to be covered via the Medicaid works option they will simply pay a monthly premium and not have to continue returning to a local office to qualify via spend down. Additionally, this option allows individuals to increase their expendable income by working and maintaining Medicaid eligibility rather than having to choose between working and preserving Medicaid benefits. The special income factors established in this administrative regulation for Medicaid works individuals exceed those established for other recipients and result from a review of other states' standards as well as feedback from the advocate community.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates that the system modifications will cost $36,275.

(b) On a continuing basis: DMS anticipates medical and pharmaceutical costs to be approximately $912,000 during the first year; however, this amount will be offset by cost sharing in the form of premiums totaling $108,000. Additionally, DMS anticipates that sixty-five (65) percent of recipients expected to enroll for coverage via the Medicaid works option will already be enrolled in another Medicaid program. Considering all factors, DMS projects total annual costs to be $211,200, of which $147,840 would be federal funds.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act, matching funds from general fund appropriations, and monthly premium payments made by recipients participating in the program.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in funding will be necessary as DMS anticipates any increased cost will be absorbed within the existing Medicaid budget.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This amendment establishes monthly premium fees for recipients eligible via the Medicaid works option.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied to monthly premium amounts. The monthly premium is based on income brackets in order to make the program affordable to individuals in the lower income brackets. Recipients whose monthly income is below 100% of the

federal poverty level will pay no premium while recipients above this level will vary with each increase of fifty (50) percent or more.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:640 Agency Contact: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

1. Federal statute or regulation constituting the federal mandate.
The Centers for Medicare and Medicaid Services (CMS) does not mandate that state Medicaid programs cover working individuals who are disabled; however, relevant provisions for states who choose to offer this coverage are established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.

2. State compliance standards.

KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

3. Minimum or uniform standards contained in the federal mandate.

CMS does not mandate that state Medicaid programs cover working individuals who are disabled; however, relevant provisions for states who choose to offer this coverage are established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170. Provisions established in this administrative regulation conform to the federal requirements.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

   This administrative regulation does not impose stricter, than federal, requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

   This administrative regulation does not impose stricter, than federal, requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:640 Contact Person: Stuart Owen (502) 564-6204 or Lisa Lee (502) 564-6890

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X__ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect an organization that chooses to hire an individual with a disability.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Relevant provisions for states who choose to offer this coverage are established in 42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC d(q)(2)(B) and Public Law 106-170. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amount of revenue this administrative regulation will generate for state or local government is contingent upon the number of individuals who enroll via the Medicaid works option. Individuals who meet criteria established by this amendment will be allowed to enter the workforce, increase their earnings and remain eligible to receive benefits. State revenue is contingent upon the number of hours of worked per individual and the rate of pay each receives.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amount of revenue this administrative regulation will generate for state or local government is contingent upon the number of individuals who enroll via the Medicaid works option. Individuals who meet criteria established by this amendment will be allowed to enter the workforce, increase their earnings and remain eligible to receive benefits. State revenue is

contingent upon the number of hours of worked per individual and the rate of pay each receives.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates that the Medicaid Management Information System (MMIS) modifications associated with this initiative will cost approximately $36,275.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates the enhanced coverage may result in additional cost; however, the measures are necessary to enhance access to health services. DMS anticipates medical and pharmaceutical costs to be approximately $912,000 during the first year. However, this amount will be offset by cost sharing in the form of premiums totaling $108,000. In addition, research shows that sixty-five (65) percent of individuals expected to participate in this option were already enrolled in another Medicaid program. DMS anticipates offsets in premiums and, due to the fact that approximately sixty-five (65) percent of recipients in this program would move from another Medicaid program, total annual costs are expected to be $211,200, of which $147,840 would be federal funds.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: